Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:		MFDR Tracking #:	M4-10-1820-01
	ALLIED MEDICAL CENTERS PO BOX 24809 HOUSTON, TX 77029	DWC Claim #:	
		Injured Employee:	
Respondent Name and Box #:		Date of Injury:	
	METROPOLITAN TRANSIT AUTHORITY BOX #: 19	Employer Name:	
		Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Statement states in part, "…our request for reconsideration we specified we were down-coding to 99213, and that code does not require pre-authorization. Documentation submitted falls within 99213 description. We have clearly documented this on our reconsideration letter, which seems to have been overlooked. Denial Reason: Payer deems the information submitted does not support this level of service and This [sic] of service is being disputed as it does not meet the components as defined in the CPT book…."

Principle Documentation:

1. DWC060
2. Initial medical bills and corrected medical bills
3. EOBs
4. Total Amount Sought $135.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

The Respondent did not respond to the DWC060 Request.

Principle Documentation:

1. None

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service and CPT code	Amount in Dispute	Amount Due
12/11/08	W4, 151	99214- Office visit for the evaluation and management of an established patient	$120.00	$15.00
		99080-73-Return to Work Form	$15.00	
Total Due:				$15.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution (MFDR) received the DWC060 on November 19, 2009. The date of service in dispute is 12/11/2008. The dispute was filed timely and eligible for review.
2. The carrier denied CPT codes 99214 and 99080 for the following reasons;
   - W4-No additional reimbursement allowed after review of appeal/reconsideration
   - 151-Paymented adjusted because the payer deems the information submitted does not support his many services.

3. Review of the CMS-1500s submitted by the Requestor indicates the health care provider billed CPT codes 99214-25 and 99080-73 on 3/4/2009. The carrier audited and denied the initial bill denial reason 151 on 12/29/08. The reconsideration bill was submitted, audited, and denied by the carrier with denial reasons W4 and 151 on 7/2/09.
4. The Requestor indicates that due to the denial, the health care provider resubmitted the bill and down coded with CPT code 99213-25 and code 99080-73. No audit EOBs were included in the dispute for CPT code 99213-25. The Requestor however is seeking reimbursement for CPT code 99214-25 and 99080-73 as indicated on the table of disputed services. Initial and reconsideration was billed to the carrier in accordance with Rule 133.250. Therefore, MFDR will audit CPT codes 99214-25 and 99080-73.
5. Review of the Requestor's position statement states in part, "…Our doctors usually spend 25-30 minutes conducting a re-evaluation of established patients. As noted in the typed subsequent report that was submitted with the HCFA billing, you can clearly note that an expanded history is documented under Present Medical Condition on our follow-up exam form. An expanded examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of low complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations."
6. CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family."
7. Review of "Follow up WC Visit" dated 12/11/08 does not meet the documentation criteria required when billing CPT code 99214-25. As a result $0.00 reimbursement is recommended.
8. Review of the DWC-73 dated 12/11/2008 contains the required information set out under Rule 129.5. As a result and in accordance with Rule 129.5 (i) the Requestor is entitled to reimbursement in the amount of $15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Section 133.307, 134.203, 129.5, 133.250

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §§413.031 and 413.019, the Division has determined that the Requestor is entitled to $15.00 reimbursement.

		April 22, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.